M423 Spenddown requirements

Medical expenses that are the current liability of the Medicaid group and for which no third party is legally liable may be deducted from total excess income or resources for the accounting period. No medical expense may be used more than once to meet a spenddown requirement. If only a portion of a medical expense is used to meet the spenddown requirement for a given accounting period, that portion of the medical bill that was not used and remains a current liability may be applied toward a subsequent spenddown requirement in a future accounting period. Upon receiving coverage, the Medicaid group remains directly responsible to providers for expenses incurred before the spenddown was met.

When a third party is liable for all or some medical expenses, only the portion that the Medicaid group is responsible for may be deducted from excess income or resources. The department must take reasonable measures to determine the legal liability of third parties to pay for incurred expenses; however, it cannot delay an eligibility determination. Eligibility must be based on an estimate of the Medicaid group's liability for the expenses whenever actual third party liability cannot be ascertained or payment by the third party has not been received.

M423.1 Spenddown computation

The amount of a Medicaid group’s spenddown is the amount by which the group’s total countable income and resources for the accounting period exceed the protected income level (P-2420 (B)) for the accounting period.

M423.11 Countable income

Countable income must be determined for each of the months in the accounting period. It includes income actually received and income expected to be received during the accounting period.

Actual income received in past and current months must be verified.

Income that a Medicaid group expects to receive in future months of the accounting period may be estimated using current facts of the group's situation. If the actual amount received during the month is different from the amount estimated, countable income for that month must be recalculated and verified before it may be used to redetermine the spenddown for the accounting period.

The spenddown level must be recalculated whenever:

- the actual amount received during the month turns out to be different from the amount estimated;
- the Medicaid group’s size or countable income changes during the accounting period; or
- the protected income level changes during the accounting period.

When a recalculation results in a higher spenddown amount, Medicaid beneficiaries become ineligible for Medicaid until they meet the new spenddown requirement.

M423 Spenddown requirements (Continued)

M423.2 Deductible expenses

Deductible expenses include medical expenses incurred:

- during the current accounting period, whether paid or unpaid;
- before the current period and paid in the current period, or
- before the current period, remaining unpaid, and for which continuing liability can be established.

In addition, deductible expenses include medical expenses paid during the current accounting period by a public program (other than the Medicaid program) of the State or a municipality.

Medical expenses incurred before or during the accounting period and paid for by a bona fide loan may be deducted if the Medicaid group establishes continuing liability for the loan and documents that all or part of the principal amount of the loan remains outstanding at any time during the accounting period. A bona fide loan means an obligation, documented from its outset by a written contract and a specified re-payment schedule. Only the amount of the principal outstanding during the accounting period, including payments made on the principal during the accounting period, may be deducted.

M423.21 Predictable expenses

In general, an expense is incurred on the date liability for the expense begins. Only four types of predictable medical expenses may be deducted before they are incurred, if it can be reasonably assumed that the expense will continue during the accounting period:

- health insurance premiums (M431);
- medically necessary over-the-counter drugs and supplies (M432.2).
- ongoing, noncovered personal care services (M432.3); and
- assistive community care services provided to residents in a level III residential care home either not enrolled as a Medicaid provider or with admission agreements specifying the resident's financial status as private pay (M432.4);

Continuing liability for unpaid medical expenses or a loan used to pay medical expenses incurred before the current accounting period will be established when any of the following conditions is met:

- The liability was incurred within six months of the date of application or the first day of the accounting period, whichever is later.
- The liability was incurred more than six months before the date of application or the first day of the accounting period, whichever is later, and there is a bill for the liability dated within 90 days of that date.
- The liability was incurred more than six months before the date of application or the first day of the accounting period, whichever is later, and the service provider or lender has confirmed that the unpaid liability has not been forgiven and is not expected to be forgiven at any time within the current accounting period.

M423 Spenddown requirements (Continued)

M423.3 Deduction sequence

Eligible medical expenses are deducted from countable income in the following order:

1. Health insurance expenses (M431).

2. Noncovered medical expenses (M432).

3. Covered medical expenses (M433, M434) that exceed limitations on amount, duration or scope of services covered (M500-M999).

4. Covered medical expenses (M433, M434) that do not exceed limitations on amount, duration or scope of services covered and are incurred by a financially responsible relative or member of the Medicaid group. These must be deducted in chronological order of the date the service was received beginning with the oldest expense.

M423.4 Eligibility date

Medicaid eligibility becomes effective on the day the spenddown requirement is met. Medicaid groups with excess income or resources meet the spenddown requirement on the first day within the accounting period that their deductible medical expenses meet or exceed the spenddown requirement (see M250.1, M330-M339). Medicaid groups remain responsible for medical expenses incurred before the date of eligibility. When they receive services from more than one provider on the day that coverage begins, Medicaid groups must decide which services they will be responsible for paying and which ones Medicaid will cover. Medicaid pays for covered services on the first day that the group's expenses exceed the amount of the group's spenddown. Medicaid continues until the end of the six-month accounting period, unless the Medicaid group's situation or protected income level changes.

For Medicaid groups who meet their spenddown requirement using noncovered assistive community care services, special eligibility dates apply as set forth in M432.44.

M430-M439 Medical Expense Deductions

M43l Health Insurance Premiums

Health insurance means insurance to meet costs of medical care and services, such as Medicare Part B, and similar group or individual policies. Premiums for the following types of insurance are not deductible:

"Income protection" or similar insurance plans designed to replace or supplement income lost due to sickness or accident; or

Automobile or other liability insurance although these may include medical benefits for the insured or his family.

Health insurance expense also includes any enrollment fees, deductibles or coinsurance imposed by Medicare or other health insurance not subject to payment by a third party (such as another insurance policy).

This deduction is allowed for premium payments by a Medicaid group member or financially responsible relative for health insurance coverage of group members or any other person for whom the member or relative is financially responsible. Coverage and premium or other expense amounts must be verified.

M432 Noncovered Medical Expenses

A deduction from excess income is allowed for necessary medical and remedial expenses recognized by state law but not covered by Medicaid in the absence of an exception for Medicaid coverage under M108, even after the applicant has met a spenddown requirement. In determining whether a medical expense meets these criteria, the commissioner may require a Medicaid applicant to submit medical or other related information to verify that the service or item for which the expense was incurred was medically necessary and was a medical or remedial expense. The patient's physician shall verify medical necessity with a written statement or prescription specifying the need, quantity, and time period covered. These medical expenses include but are not limited to expenses for the services and items listed below:

- noncovered over-the-counter drugs and supplies (M432.1);
- transportation (M432.2);
- personal care services for recipients age 21 and older (M432.3);
- assistive community care services provided to residents in a level III residential care homes either not enrolled as a Medicaid provider or with admission agreements specifying the resident's financial status as private pay (M432.4);
- dental services in excess of the allowable annual maximum; and
- private duty nursing services for recipients age 21 and older.

M430-439 Medical Expense Deductions

M432 Noncovered Medical Expenses (Continued)

Any medical bills, including those incurred during a period of Medicaid eligibility, that are the current liability of the applicant and have not been used to meet a previous spenddown requirement may be deducted from excess income. Generally, the applicant is required to present a bill or receipt to verify that medical expenses have been incurred or paid. Special requirements for certain medical expenses are specified in M432.1 – M432.3.

M432.1 Noncovered over-the-counter drugs and supplies

Either a standard deduction or actual costs, if greater, may be used to deduct noncovered over-the-counter drugs and supplies from excess income.

M432.12 Documentation

Documentation verifying medical necessity is not required when the department determines that an over-the-counter drug or supply is a common remedy for the medical condition of the applicant and the usage is within the maximum amount for common over-the-counter drugs and supplies (P-2424C). Documentation verifying medical necessity may be required whenever one or both of the following two situations apply: when the drug or supply is not a common remedy for the medical condition or when the reported usage exceeds the maximum amount.

M432.13 Amount deductible

Instead of actual expenses, a reasonable estimate of ongoing expenses for over-the-counter drugs and supplies may be applied prospectively to the six-month accounting period. Reasonable estimates of unit sizes, costs and maximums for common over-the counter drugs and supplies used to meet the spenddown requirement are found in the procedures manual at P-2424(C). If the applicant uses the expense to meet the spenddown requirement, the applicant shall not be eligible to receive Medicaid coverage during that accounting period for the same expenses.

M432.2 Transportation

Commercial and private transportation costs may be deducted from excess income.

The actual cost of commercial transportation, verified by receipt, may be deducted.

M430-439 Medical Expense Deductions

M432 Noncovered Medical Expenses (Continued)

M432.2 Transportation (Continued)

Either a standard deduction or actual costs, if greater, may be used for deducting the cost of private transportation. These costs may be deducted from excess income without verification of medical necessity, provided that:

- the transportation was essential to secure the medical service; and
- the Medicaid applicant was responsible for the cost and charged an agreed-upon fee or purchased fuel to use a family-owned vehicle or other non-commercial vehicle.

The process set forth in Medicaid procedures (P-2424D) shall determine the deductible expense for private transportation.

M432.3 Noncovered personal care services

The department will allow a deduction for noncovered personal care services provided in an applicant's own home or in a level IV residential care home when they are medically necessary in relation to an applicant's medical condition.

M432.31 Deductible personal care services

Deductible personal care services include those personal care services described in M740.3, assistance with managing money, and general supervision of physical and mental well-being where a physician states such care is required due to a specific diagnosis, such as Alzheimer's disease or dementia or like debilitating diseases or injuries. Room and board is not a personal care service.

M432.32 Qualified service providers

Services may be deducted when performed by a home health agency or other provider identified by the physician as qualified to provide the service with the following exceptions. Deductions may not be based on payments for personal care services provided:

- to an applicant under age 21 by his or her parent, stepparent, or legal guardian; or
- to an applicant by his or her spouse; or
- to an applicant by his or her sibling, child, or grandchild when the individual providing the services is under age 18; or
- to an applicant by the parent of a child in common with the applicant.

M430-439 Medical Expense Deductions

M432 Noncovered Medical Expenses (Continued)

M432.3 Noncovered personal care services (Continued)

M432.33 Documentation

To document the need for personal care services, the physician must submit:

- a plan of care (DSW 288B);
- a list of the personal care services required;
- a statement that the services are necessary in relation to a particular medical condition; and
- a statement that the level of care provided by the particular level IV residential care home is appropriate or, if the applicant is not living in a level IV residential care home and the services are not provided by a home health agency, that the provider is qualified to provide the service.

Upon the initial submission of a plan of care (DSW 288B), it is assumed that the applicant will continue to need the personal care services for the entire six-month period, unless the plan of care has specified a date by which the applicant's need for services is expected to change.

A new plan shall be submitted:

- whenever the service provider changes, unless the service is performed by a home health agency; and
- whenever the need for services in relation to the applicant's condition is expected to change, according to the current plan of care.

In addition, a new plan shall be submitted:

- once every six months, when the physician has not specified an ongoing need for personal care services in the current plan; or
- once every two years, when the physician has specified an ongoing need for personal care services in the current plan.

M432.34 Amount deductible

Either a standard deduction or actual costs, if greater, may be used for deducting personal care services from excess income. Expenses that have not been incurred yet may be deducted if they are predictable and meet the requirements in M423.21. Expenses also may be deducted if they have actually been incurred by the applicant and are not subject to payment by Medicaid or any other third party.

M430-439 Medical Expense Deductions

M432 Noncovered Medical Expenses (Continued)

M432.3 Noncovered personal care services (Continued)

M432.34 Amount deductible (Continued)

The standard monthly deduction for personal care services (P-2420(D)(12)) shall be deducted for each full or partial calendar month in the accounting period during which the plan of care documents the need for services. The actual documented costs of personal care services may be deducted if they exceed the monthly standard deduction (P-2424). Deductions may be made for anticipated need through the end of the accounting period.

All changes to these standards that result in lower standard deductions will be made via the Administrative Procedures Act.

M432.4 Noncovered assistive community care services

M432.41 Deductible assistive community care services

The department will allow a deduction for assistive community care services provided to applicants either residing in a level III residential care home not enrolled as a Medicaid provider, or residing in a Level III residential care home enrolled as a Medicaid provider and having an admission agreement specifying the resident's financial status as private pay. In addition, these applicants may deduct medically necessary personal care services included under the list at M740.3 but not part of the list at M781.2.

M432.42 Qualified service providers

Qualified service providers include all level III residential care homes licensed by the Vermont Department of Aging and Disabilities (see P-2420D(12)). These providers must provide each privately paying resident with a "resident agreement" that includes a condition stating that when a privately paying resident becomes eligible for Medicaid after having met a spenddown requirement by projecting the cost of ACCS across the entire six-month spenddown period, the resident shall remain in "private-pay" status for the duration of the six-month spenddown period and the home shall not function as a Medicaid provider of ACCS with respect to that privately paying resident.

M432.43 Documentation

Documentation verifying medical necessity is not required for assistive community care services. If an applicant claims a deduction for medically necessary personal care services included under the list at M740.3 but not part of the list at M781.2, the physician must submit:

- a plan of care (DSW 288B);
- a list of the personal care services required;
- a statement that the services are necessary in relation to a particular medical condition; and
- a statement that the level of care provided by the particular level III residential care home is appropriate and that the provider is qualified to provide the service.

M430-439 Medical Expense Deductions

M432 Noncovered Medical Expenses (Continued)

M432.4 Noncovered assistive community care services (Continued)

M432.43 Documentation (Continued)

Upon the initial submission of a plan of care (DSW 288B), it is assumed that the applicant will continue to need the personal care services for the entire six-month period, unless the plan of care has specified a date by which the applicant's need for services is expected to change.

Beneficiaries with approved personal care services deductions must submit new plans at the frequencies specified in M432.33.

M432.44 Amount deductible

The standard monthly deduction for assistive community care services (P-2420(D)(12)) shall be deducted for each full or partial calendar month in the accounting period. The actual documented costs of assistive community care services may be deducted if they exceed the monthly standard deduction (P-2424). Deductions may be made for anticipated need through the end of the accounting period. All changes to these standards that result in lower standard deductions will be made via the Administrative Procedures Act.

In addition, the amount of the deduction for any services included under the list at M740.3 but not part of the list at M781.2, which the plan of care documents as medically necessary, shall be determined by based on the number of hours times minimum wage, or actual costs, if greater.

M433 Covered Medical Services

Covered medical expense means any medical service that Medicaid would pay for if the person were an eligible Medicaid recipient (see Sections M500-M999).

Deductions are not limited to the Medicaid reimbursement for the service. The Medicaid group member's actual cost paid or incurred must be allowed. A standard deduction may be taken for assistive community care services, M781.2, as specified in Medicaid procedures at P-2420(12).

M434 Expenses Subject to Third-Party Coverage

No deduction is allowed if the medical expense is subject to payment by a third party such as health insurance, worker's compensation, liability award, or other benefit program unless the third party is a public program (other than Medicaid) of the State or a municipality. Estimates of payment by the third party may be used if actual third party liability cannot be ascertained within the time frames for determining Medicaid eligibility. If an applicant or recipient is pursuing a liability award but liability has not yet been established, a deduction should be allowed. However, the Third Party Liability (TPL) unit in the Medical Services Division should be notified of the pending potential liability award when the applicant is found eligible for Medicaid.